Lymphoma-like syndrome following *para*-aminosalicylic acid

N. NAGARATNAM
M.D., F.R.C.P., F.A.C.C.

N. BHUVANENDRAN
M.B.

A. J. JIFFRY
M.B.

VINODHINI RAMACHANDRA
M.B.

General Hospital, Colombo, Sri Lanka

Summary

This report describes a patient who developed a Hodgkin's disease-like picture both clinically and pathologically, following the administration of *para*-aminosalicylic acid, with complete regression on cessation of therapy.

Introduction

A lymphoma-like syndrome, both clinical and pathological, induced by anti-convulsant drugs, especially of the hydantoin group, has been described (Saltzstein and Ackerman, 1959). Hodgkin's disease and malignant lymphoma developing during anti-convulsant therapy has also been recorded (Hyman and Sommers, 1966). We wish to report a patient who developed a lymphoma-like syndrome following *para*-aminosalicylic acid.

Case report

A 40-year-old male was seen in May 1976 at a local hospital, with fever and chest pain. Examination revealed a left-sided pleural effusion which on aspiration yielded 500 ml of straw-coloured fluid. He was treated with penicillin for 10 days with no benefit. He was then administered standard anti-tuberculous drugs—streptomycin, isoniazid and *para*-aminosalicylic acid (PAS). Two weeks later, the patient developed high fever with chills followed by a generalized erythematous rash and generalized lymphadenopathy. He was then transferred to our unit, and examination revealed a febrile patient with generalized lymphadenopathy, hepatomegaly and an erythematous rash. The spleen was not palpable and he was not jaundiced. The lymph nodes were large (2-3 cm), discrete, rubbery and non-tender. The lungs were clear.

Laboratory investigations

The total white cell count was 14×10^9 /litre with 38% eosinophils. The erythrocyte sedimentation rate (Westergren method) was 50 mm in the first hour, prothrombin time 24 secs (control 18 secs) and the serum glutamic pyruvic transaminase was 22 iu./litre.

An X-ray of the chest showed minimal pleural thickening on the left side. A cervical lymph node biopsy was performed, and revealed changes suggestive of Hodgkin's lymphoma (mixed cellularity type). There was considerable distortion of the architecture, with numerous reticulum cells and mitotic figures. No Dorothy Reed cells were seen.

The anti-tuberculous drugs were discontinued on the day of admission. The patient became afebrile the following day and the rash subsided over the next 4-5 days. The liver and the lymph nodes receded gradually over 2 weeks and were minimal at the end of this period when the patient was discharged from our unit. He was regularly followed up and 5 years later remains in good health with no recurrence of the lymphadenopathy. The white cell count was normal.

Discussion

Lymphadenopathy, hepatomegaly and eosinophilia associated with fever and a scarlatiniform or morbilliform rash are recorded manifestations of PAS sensitivity. The disorder resolves in a few weeks after the drug is withdrawn. Our patient remains well 5 years after the onset of his illness, with no recurrence of his lymphadenopathy. Whether he will eventually develop a lymphoma is a moot point.

Angio-immunoblastic lymphadenopathy, recently described by Frizzera, Moran and Rappaport (1974) has features that are similar to PAS sensitivity being associated frequently with either polyclonal gammo-

pathy or a Coombs-positive haemolytic anaemia, or both. In this entity, although the histology may at first suggest a lymphoma, the appearances are characterized by destruction of the lymph node architecture by a mixed cellular proliferation of immunoblasts associated with plasmacytoid and plasma cells. There is a striking proliferation of arborizing small vessels and deposition of acidophilic staining interstitial material. The cause is not known, but according to Lukes and Tindle (1975) it may be an indication of an underlying abnormal immune state triggered into an exaggerated response and drug hypersensitivity could be the initial event.

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